

2012

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Recommended Citation

Gonzalez, Jennifer E. (2012) "Influence of Family and Victim Demographic Factors on Treatment Completion for Children Exposed to Abuse and Family Violence," *The Pegasus Review: UCF Undergraduate Research Journal (URJ)*: Vol. 6 : Iss. 2 , Article 6.

Available at: <https://stars.library.ucf.edu/urj/vol6/iss2/6>



Influence of Family and Victim Demographic Factors on Treatment Completion for Children Exposed to Abuse and Family Violence

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ABSTRACT: The Children’s Bureau of Administration on Children, Youth, and Families (2010) estimates that over 75 million children disclose being victims of sexual abuse, physical abuse, neglect, psychological maltreatment, and medical neglect each year. However, for agencies that provide services to victims of child sexual abuse and neglect, successfully completing treatment for clients is challenging but imperative in decreasing the likelihood of the child or adolescent developing long-term emotional, psychological, and behavioral consequences (DePanfilis, 2006). According to McPherson, Scribano, & Stevens (2012), child survivors of sexual abuse are more likely to complete treatment if their mother attends sessions and supports the child throughout the counseling process. The present study examines the influence of demographic factors on treatment completion of 292 children who received services from a child advocacy center. The findings identify differences between caregivers’ type of relationships to the victims and appointment cancellations.

KEYWORDS: child abuse, demographic factors, families of child abuse victims, caregiver relationships, treatment plans, appointment cancellations

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INTRODUCTION

The Federal Child Abuse Prevention and Treatment Act of 1984 (CAPTA) defines child abuse as "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm" (15). The Children's Bureau of Administration on Child, Youth, and Families (2010) reported that over 75 million children identified themselves as victims of maltreatment. The incidence of child abuse may be much higher and indicate severe underreporting of injuries and fatalities due to child abuse and neglect (Finkelhor 1993; Kenny 2001; Zellman & Fair 2002). Children and society may experience several outcomes as a result of said abuse.

Negative outcomes resulting from child abuse and neglect manifest themselves physically, psychologically, behaviorally, and/or socially (DePanfilis 2006). Physical consequences include impaired brain development, smaller brain size, chronic health problems, severe injuries, poor muscle tone, inability to vocalize, and unresponsiveness (Irish, Kobayashi, & Delahanty 2010; Malinosky-Rummell & Hansen 1993; Sachs-Ericsson, Medley, Kendall-Tackett, & Taylor 2011). Signs of psychological consequences include inability to trust, seclusion, and higher risk of developing a psychiatric disorder such as anxiety, depression, eating disorders, dissociative disorders, attention deficit hyperactivity disorder (ADHD), post traumatic stress disorder (PTSD), and reactive attachment disorder (Barlow 2002; Heim, Shugart, Craighead, & Nemeroff 2010; Stevenson 1999). Heim and colleagues (2010) and Phasa (2008) found that maltreated children performed poorly on academic tests, demonstrated delays in developing language and math abilities, and showed difficulty in making friendships. Signs of behavioral consequences of child abuse include: engaging in risky behaviors such as (a) abusing alcohol or drugs, (b) having unsafe sex that can lead to a sexually transmitted disease or pregnancy, and (c) taking part in juvenile criminal activity (Koenig & Clark 2004; Lown, Nayak, Korcha, & Greenfield 2011; Roe-Sepowitz 2009). DePanfilis (2006) notes that child victims of abuse present with greater risk for developing a conduct disorder, and over a third of those victims maltreat their own children later in life. Society also pays a price for the abuse of these children through direct and indirect costs. DePanfilis (2006) identifies the direct costs of child abuse as amounting to \$24 billion annually, including expenses for child abuse and neglect centers,

law enforcement involved with investigations, judicial workers involved with any prosecutions and mental health professionals involved with caring for abused children. The Children Welfare Information Gateway (2008) reports the indirect costs of child abuse include the associated costs from criminal activity, substance abuse, violence in the homes of families, and psychiatric disorders. These outcomes support the necessity for children to complete therapeutic treatment to address, and possibly prevent, the abuse.

Demographic factors of victims of child abuse and neglect and their caregivers have been investigated to identify the predictors of a child being abused in his or her lifetime as well as completion of his or her treatment plan. For example, McPherson, Scribano, and Stevens (2012) found no difference among children ($N = 490$) who did and did not complete treatment in regard to demographic factors or severity of abuse. However, McPherson and colleagues identified the level of active participation of the non-offending caregiver as a positive predictor of successful treatment outcomes. In addition, the attrition rates for victims of child abuse and neglect drop in relation to minority status, lower socioeconomic status, caregiver's perception of the relationship between the child and the therapist, history of mental illness in the family, and less severe or less chronic abuse (Jones & McCurdy 1992; Horowitz, Putnam, Noll, & Trickett 1997; Fundudis, Kaplan, & Dickinson 2003). Based on this information, treatment completion data should be researched to determine the factors that influence the likelihood of treatment completion and emphasize those factors throughout treatment.

The purpose of the present study is to examine treatment completion data from a community agency that provides services to child survivors of physical and sexual abuse. The two research questions guiding the investigation are: (a) What is the relationship between family demographic factors of child survivors of physical and sexual abuse and their treatment completion? and (b) What is the relationship between the demographic factors of child survivors of physical and sexual abuse and their treatment completion?

METHODS

Participants

Participants in this study were clients in a child advocacy center serving children victimized by physical

and sexual abuse or exposed to family violence. To collect participant data, the center utilizes NCATrak, a nationwide database employed by child advocacy centers that includes information regarding each allegation of abuse. Participants included clients seen in 2009 and 2010. Data for this study addresses 292 child victims of physical and sexual abuse. The average age of the victims was nine years old ($SD = 4.15$; range, 2–18). Fifty-four percent of victims identified as White ($n = 157$) and 17% Black/African American ($n = 49$). Two categories divided the Hispanic participants: White Hispanic/Latino and Black Hispanic/Latino. Twenty percent of victims were White Hispanic/Latino ($n = 59$), and Black Hispanic/Latino was 2% ($n = 6$). Asians were the lowest reported, with only .7% ($n = 2$). Female victims were the majority of clients at 64% ($n = 187$), with males at 36% ($n = 104$). Biological mothers were the primary caregiver most reported at 53% ($n = 155$), followed by biological fathers at 25% ($n = 73$), and other relatives, such as adoptive parents or grandparents, at 19% ($n = 55$). Fifty-five percent of primary caregivers had an income under \$30,000 ($n = 159$) and 27% were over \$30,000 ($n = 79$). The average of the primary caregiver's age was 38 ($SD = 10.3$; range, 18 to 78).

Instruments

The child advocacy center utilizes NCAtrak (National Children's Alliance, 2009) as its management information system to record data about its clients and abuse allegations. NCAtrak brings the various users of the center (i.e., Child Protective Services, law enforcement, lawyers, and county agencies) together in one system. At the agency's point of entry, staff input data into NCAtrak in one or more of the ten tabs (general information, people, multi-disciplinary team, presenting information, Child Protective Services, law enforcement, medical, forensic interview, victim advocacy program, and mental health). The general information section documents the demographics of both victim and caregiver. The people section includes a biography of the victim. The multi-disciplinary team discusses which teams were involved, such as law enforcement, community based care, and the state attorney, and how cohesively they worked. The presenting information section reviews the background information surrounding the allegation, such as where and what type of abuse occurred, and the substantiation of the allegation. The Child Protective Services and law enforcement sections record which agency initiated an investigation. If a medical examination or forensic interview becomes necessary to document evidence

of abuse, the respective sections record the results of either the examination or interview. The victim advocacy program describes the therapeutic services provided by the center and reports details of the services. Finally, the mental health section specifies the victim's scores on the assessment given, the type of counseling sessions given, and session attendance. For this study, we obtained data from the various sections and imported it into SPSS (Statistical Package for Social Sciences) for analyses. The variables included: (a) victim's relationship to primary caregiver, (b) victim's gender, (c) caregiver's gender, (d) caregiver's income, (e) victim's age, and (f) caregiver's age. These demographic variables were taken from the general information section of the dataset.

Procedures

The local child advocacy center caters to children and adults in the local region whenever abuse is alleged. Clients are referred to the advocacy center from other community resources. To begin treatment, potential clients must first be screened by one of the therapists on staff to determine if the services are appropriate to the client's needs. After passing the screening, a treatment plan is created and the client is ready to begin treatment. Prior to collecting data, the researchers requested approval from the university's Institutional Review Board (IRB) for human subjects research to conduct the study. IRB approved the study as exempt. The agency sanitized the NCAtrak data by removing all client identifying information and provided it to the research team in Microsoft Excel files. The files were merged into one Excel spreadsheet and then imported into SPSS. Four univariate analyses of variances (ANOVA) were conducted to examine the differences among family demographics, victim factors, and treatment attendance. Two linear regressions were employed to examine the relationship between victim's age and treatment attendance and to examine the relationship between caregiver's age and treatment attendance.

RESULTS

A preliminary analysis was done to verify this dataset did not violate the assumptions of ANOVAs so the analysis could be performed. There are six assumptions of linear regressions: level of measurement, random sampling, independence of observations, normal distribution, homogeneity of variance, and missing data/outliers. Level measurement was taken into account via the use of continuous scale instead of discrete categories. The

researchers attempted to use a random sample but it is difficult to do so due to the population being investigated. A correlation matrix tested for independence of observations. A histogram, normal Q-Q plot, and detrended Q-Q plot verified for normal distribution. Homogeneity of variance was tested through the use of Levene's test for equality, resulting in no significance. Box plots were utilized to search for outliers, with none found. No missing data were found. Results of the preliminary analyses presented no concerns in moving forward with the analyses of data.

The first ANOVA examined the differences between primary caregiver's relationship to victim (mother, father, adoptive parent, or other relative) and treatment attendance. The average number of children who canceled sessions with the biological mother as primary caregiver was 6.06 ($M = 6.06$, $SD = 5.15$), while the average number of children who canceled sessions with their biological father as primary caregiver was lower ($M = 4.29$, $SD = 3.61$) (See Table 1). A statistically significant difference was found for primary caregiver's relationship to the victim, $F(1, 125) = 4.2$, $p = .04$, with more sessions canceled with the biological mother as the primary caregiver. However, the effect size was small at .03 (Cohen, 1988). The second ANOVA examined the differences between victim's gender and treatment attendance, and indicated no differences (See Table 2). The third ANOVA examined the differences between primary caregiver's gender and treatment attendance and no differences were identified (See Table 1). The last ANOVA examined the differences among primary caregiver's income and treatment attendance. No differences were identified (See Table 1).

The first linear regression examined the relationship between victim's age and treatment attendance. Results indicated no significant relationships, $F(3, 97) = 1.15$, $p = .34$ (See Table 2). The second linear regression examined the relationship between caregiver's age and treatment attendance. We found no significant relationship, $F(3, 89) = 1.6$, $p = .19$ (See Table 2).

DISCUSSION

We found a significant difference in that more counseling appointments were cancelled with the biological mother as primary caregiver than with the biological father. A number of factors might contribute to this finding. Research indicates that cohabiting boyfriends and male partners of mothers perpetrate many incidents of child

abuse (Berger, Paxson, & Waldfogel 2009; Daly & Wilson 2008; Lee, Lightfoot, & Edleson 2008). Additionally, some women remain with the abuser, which can complicate aspects of treatment (Alaggia 2001; Lipovsky 1991) such as attendance. The abuser may control the actions of the mother and child and create barriers such as removing their method of transportation, controlling their funds, or threatening harm. Another potential consideration is the difficulty women encounter when leaving their abuser, which might require relocation resulting in inconsistencies in treatment attendance and premature treatment cessation. Although limitations exist, which will be presented below, there were non-significant findings in this study that have relevance in identifying demographic characteristics that might not influence treatment attendance. Researchers investigating factors influencing treatment attendance can now ask more sophisticated questions related to victim or caregiver age and caregiver income along with more qualitative areas of inquiry. However, it is important to note the center that contributed data served a low resource, uninsured, or minimally insured population. Thus, additional investigations could identify potential influence of income, controlling for insurance status, or between private practice and agency clients.

Limitations in this study include examining demographic variables available, which possibly impacted treatment attendance. However, a number of other variables demonstrate the potential to impact treatment attendance not collected by the NCAtrak. Although a difference between the biological mother and father in the number of sessions canceled was noted, we did not examine contributions to this difference. Additionally, we analyzed data from a community social service agency with no private practice representation. Thus, any conclusions would be limited to agency populations. Finally, the small effect size found with the significant finding suggests the need for some caution with these findings and what they suggest. Nonetheless, research demonstrates the positive impact of treatment attendance and completion in child abuse victims, so additional contributions help complete the picture needed to address and mitigate the problem on treatment non-completion.

Implications of this study include delving further, particularly through qualitative approaches, into why biological mothers may cancel more sessions and how this data affects the child advocacy center's retention rate, organization, and overall effectiveness. Qualitative approaches are recommended because they allow for the

clients to discuss their experiences subjectively at a more intimate level than quantitative approaches can provide (Crisma, Bascelli, Paci, & Romito, 2004). An abundance of research offers various reasons for low session attendance, including the mother being a victim of abuse, the parent being the abuser, the abuser living in the household, the mother feeling guilt or shame for not properly protecting her child, and the mother's cultural or religious beliefs (Alaggia 2001; Baker 2001; Boroughs 2004; Plummer & Eastin 2007b; Lippert, Favre, Alexander, & Cross 2008). This data will help counselors identify strategies to increase retentions with clients whose biological mother is their primary caregiver. Other common causes of low retention include lack of transportation, inability to pay for services, and the caregiver not feeling supported by the center (Meddin & Hansen 1985; Plummer & Eastin 2007a; Thompson 2005). Centers need to collect additional data, quantitative and qualitative, to better identify potential factors for greater or lower levels of treatment attendance. For example, gathering data on potential barriers to treatment—such as transportation, financial distress, stability of residence, and self-report of perceived barriers—provides counselors with additional data to help them mitigate barriers. This process also provides researchers more data to investigate which barriers prove more challenging for different clients.

Prior research on demographic factors of family and victims is slim and the focus of the studies differed slightly. Age of child, type and frequency of abuse, ethnicity, level of law enforcement involvement, and caregiver perspective on therapy are examples of factors investigated in previous research (Cohen & Mannarino 1998; Lippert et al. 2008; McPherson et al. 2012; Tingus, Heger, Foy, & Leskin 1996). Only two articles examined the relationship between these demographic factors and treatment completion and the results from both studies are similar (Lippert et al. 2008; McPherson et al. 2012). The researchers of this study did not have access to the caregivers or the children to ask them their thoughts on the treatment; therefore, they could only infer about the cancellation of sessions based on the results from similar, published research.

CONCLUSION

This study evaluated variables collected by a child advocacy center to determine their influence on the treatment attendance of children receiving services for abuse. Results found a significant difference, albeit small effect size, in child abuse victims who receive counseling

services having more appointment cancellations with primary caregiving biological mothers as opposed to biological fathers. Future research, with mixed methods designs of qualitative inquiry, may further unpack this finding. The researchers of this study acknowledge that males, particularly romantic partners and live-in boyfriends, perpetrate more child abuse, especially sexual abuse, than women. The finding from this study, along with the non-significant findings suggesting demographic characteristics that do not influence treatment completion, indicate the need for further research on additional factors that contribute to lower levels of treatment attendance. This will assist in implementing techniques to prevent early discharge from child-care agencies.

APPENDIX



Table 1. Treatment Attendance and Demographic Factors for Victims and Caregivers

| Session Attendance | Group | <i>M</i> | <i>SD</i> |
|--------------------|-------------------|----------|-----------|
| Number Attended | Biological Mother | 13.05 | 12.72 |
| | Biological Father | 10.84 | 6.85 |
| Number No Show | Biological Mother | 3.52 | 2.75 |
| | Biological Father | 2.86 | 2.23 |
| Number Cancelled | Biological Mother | *6.06 | *5.15 |
| | Biological Father | 4.29 | 3.61 |
| Number Attended | Male Victim | 11.7 | 11.27 |
| | Female Victim | 12.93 | 10.93 |
| Number No Show | Male Victim | 3.56 | 3.2 |
| | Female Victim | 3.34 | 2.56 |
| Number Cancelled | Male Victim | 4.93 | 4.29 |
| | Female Victim | 5.39 | 4.71 |
| Number Attended | Male Caregiver | 11.65 | 8.52 |
| | Female Caregiver | 13.08 | 12.23 |
| Number No Show | Male Caregiver | 3.05 | 2.04 |
| | Female Caregiver | 3.59 | 3.13 |
| Number Cancelled | Male Caregiver | 4.92 | 4.36 |
| | Female Caregiver | 5.5 | 4.69 |
| Number Attended | <\$30K | 12.46 | 11.49 |
| | >\$30K | 12.84 | 11.44 |
| Number No Show | <\$30K | 3.6 | 2.95 |
| | >\$30K | 3.19 | 2.62 |
| Number Cancelled | <\$30K | 5.57 | 5.14 |
| | >\$30K | 3.22 | 4.3 |

* $p < .05$

Table 2. Treatment Attendance by Age

| Session Attendance for Victims | | <i>M</i> | <i>SD</i> |
|-----------------------------------|---------------------|----------|-----------|
| | Number of Attended | 13.91 | 11.2 |
| | Number of No Shows | 3.3 | 2.43 |
| | Number of Cancelled | 3.69 | 4.92 |
| Session Attendance for Caregivers | | <i>M</i> | <i>SD</i> |
| | Number of Attended | 13.78 | 11.12 |
| | Number No Shows | 3.26 | 2.48 |
| | Number Cancelled | 5.71 | 5.01 |

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